

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
61 Forsyth St., Suite 4T20  
Atlanta, Georgia 30303-8909



October 11, 2007

Mr. Shawn M. Crouch  
Commissioner  
Department for Medicaid Services  
Sixth Floor  
275 East Main Street  
Frankfort, Kentucky 40621-0001

Attention: Kevin Skeeters

RE: Kentucky Title XIX State Plan Amendment, Transmittal #07-006

Dear Mr. Crouch:

We have reviewed the proposed amendment to the Kentucky Medicaid State Plan that was submitted under transmittal number 07-006. This amendment gives you the authority to submit State Plan amendments for the Department for Medicaid Services.

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 07-006 was approved on October 10, 2007. The effective date for this amendment is September 1, 2007. We are also enclosing the approved HCFA-179 and plan page.

If you have any questions or need any further assistance, please contact Maria Donatto at (404) 562-3697.

Sincerely,

Jay Gavens  
Acting Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
07-006

2. STATE  
Kentucky

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
September 1, 2007

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:  
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:  
a. FFY 2005 \$0  
b. FFY 2006 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
  
Page 89

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):  
  
Same

10. SUBJECT OF AMENDMENT:

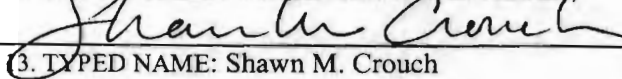
State Governor's Review

11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Review delegated  
to Commissioner, Department for Medicaid  
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Shawn M. Crouch

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: September 12, 2007

16. RETURN TO:

Department for Medicaid Services  
275 East Main Street 6W-A  
Frankfort, Kentucky 40621

**FOR REGIONAL OFFICE USE ONLY**


17. DATE RECEIVED:  
September 13, 2007

18. DATE APPROVED: October 10, 2007

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
September 1, 2007

20. SIGNATURE OF REGIONAL OFFICIAL:

  
22. TITLE: Acting Associate Regional Administrator  
Division of Medicaid & Children's Health Opns

21. TYPED NAME:  
Jay Gavens

23. REMARKS:

State: Kentucky

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## Citation

7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

☒ Not Applicable. The Governor-

☒ Does not wish to review any plan material.

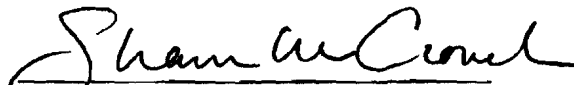
☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services

(Designated Single State Agency)

Date: September 1, 2007

  
(Signature)

Shawn M. Crouch, Commissioner  
Department for Medicaid Services  
(Title)

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TN#: 07-006

Supersedes

TN#: 06-011Approval Date: 10/10/07Effective Date: 9/1/2007



CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF THE UNDERSECRETARY FOR HEALTH

Ernie Fletcher  
Governor

DEPARTMENT FOR MEDICAID SERVICES  
COMMISSIONER'S OFFICE  
275 E. Main Street, Mailstop 6W-A  
Frankfort, KY 40621  
(502) 564-4321  
Fax (502) 564-0509  
[www.chfs.ky.gov](http://www.chfs.ky.gov)

Mark D. Birdwhistell  
Secretary

September 12, 2007

Renard L. Murray, D.M.  
Associate Regional Director  
Centers for Medicare and Medicaid Services  
61 Forsyth Street, SW, Suite 4T20  
Atlanta, Georgia 30303-8909

Dear Dr. Murray:

Kentucky Title XIX State Plan Transmittal No. 07-006,  
State Governor's Review

Enclosed for your review and approval is Kentucky Title XIX State Plan Amendment No. 07-006. This amendment shows that I, as Commissioner, Department for Medicaid Services, have been authorized to submit plan amendments for the Department for Medicaid Services, the designated single state agency. A copy of the letter from Secretary Mark D. Birdwhistell providing this authority is enclosed.

All correspondence relating to the Medicaid Program should be sent to my office.

Please let me know if you have any questions relating to this matter.

Sincerely,

A handwritten signature in cursive script, reading "Shawn M. Crouch".

Shawn M. Crouch  
Commissioner

SC/cb/ks

Enclosure



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☒ OTHER, AS SPECIFIED: Review delegated  
to Commissioner, Department for Medicaid  
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Shawn M. Crouch

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: September 12, 2007

16. RETURN TO:

Department for Medicaid Services  
275 East Main Street 6W-A  
Frankfort, Kentucky 40621

**FOR REGIONAL OFFICE USE ONLY**

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18. DATE APPROVED:

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

State: Kentucky

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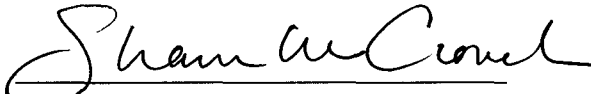
☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services

(Designated Single State Agency)

Date: September 1, 2007

  
(Signature)

Shawn M. Crouch, Commissioner  
Department for Medicaid Services  
(Title)

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TN#: 07-006

Supersedes

TN#: 06-011

Approval Date: \_\_\_\_\_

Effective Date: 9/1/2007



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF THE SECRETARY FOR HEALTH**

**Ernie Fletcher**  
Governor

275 E. Main Street, Mailstop 5W-A  
Frankfort, KY 40621-0001  
(502) 564-7042  
Fax (502) 564-7091  
[www.chfs.ky.gov](http://www.chfs.ky.gov)

**Mark D. Birdwhistell**  
Secretary

**September 12, 2007**

**Shawn M. Crouch**  
Commissioner  
Department for Medicaid Services  
275 East Main Street, 6W-A  
Frankfort, Kentucky 40621

Dear Mr. Crouch,

Please be advised that in your capacity as Commissioner, you will serve as the Governor's designee under 42 CFR 430.12(b) for review and approval of the Title XIX State Plan and State Plan Amendments. This appointment shall take effect on September 1, 2007.

I appreciate your acceptance of these duties.

Sincerely,

A handwritten signature in black ink, reading "Mark D. Birdwhistell".

**Mark D. Birdwhistell**  
Secretary

MDB/cb/ks